CHAPTER V

BILLING INSTRUCTIONS

CHAPTER V
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CHAPTER V
BILLING INSTRUCTIONS

INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800)-924-6741
Fax number: (804)-273-6797
First Health's. website: http://virginia.fhsc.com, or by mail

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim. On the CMS-1500 (12-90) form, enter "ATTACHMENT" in Locator.

- **Denied Claims** Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the UB claim form invoice as explained under the "Instructions for the Use of the UB92 or UB-04 Billing Form" are elsewhere in this chapter.

  - **Attach** written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See Exhibits.)

    Submit the claim in the usual manner by mailing the claim to:
    Department of Medical Assistance Services
    P. O. Box 27443
    Richmond, Virginia 23261-7443

  The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid can make no reimbursement if the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid can make no reimbursements if the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

- **Other Insurance** - The recipient can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid recipient. For recipients with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while you have Medicaid without penalty from your insurance company. The recipients must notify the insurance company. The recipient must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

BILLING INVOICES

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below are the four billing invoices to be used:

- Health Insurance Claim Form, CMS-1450 (UB-92) – this version is acceptable until 5/22/07.

- Health Insurance Claim Form, CMS-1450 (UB-04) – this version only accepted on/or after May 23, 2007.

- Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30) Rev 05/06.

- Title XVIII (Medicare) Deductible and Coinsurance Adjustment Void Invoice (DMAS-31) Rev 05/06.

The requirement to submit claims on an original CMS-1450 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice. Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare

claims for Medicaid recipients who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible recipients are automatically submitted to DMAS. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to Medicaid.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their NPI Provider Number as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a NPI Provider Number, the claim will be processed by DMAS using the NPI Provider Number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier "ID" in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the NPI Provider Number on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims.

Effective March 26, 2007 (NPI dual use) DMAS will no longer attempt to match a Medicare provider number to a Medicaid provider number. If an NPI is submitted, DMAS will "only" use this number. DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

REPLENISHMENT OF BILLING MATERIALS

A general rule, DMAS will no longer provide a supply of agency forms, which can be downloaded from the DMAS web site www.dmas.state.va.us. To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. The form name or number will be on the form examples in the exhibits section.

If you do not find the form with the form name or number you are searching for, with the "provider" selected, key "all Types" as the Type: and key "All Categories" as the Category with no name or form number. This will return all current provider forms available on the Department of Medical Assistance Services web site, print settings should be set at 100% actual size and page scaling "none". If you do not have Internet access, you may request a form for copying by calling the DMAS forms order desk at 1-804-780-0076.

Any requests for information, or questions concerning the ordering of forms, please contact the DMAS forms order desk at 1-(804)-780-0076. The Title XVIII (Medicare) Deductible & Coinsurance Invoice (DMAS-30) Rev 05/06 and the Title XVIII (Medicare) Deductible & Coinsurance Adjustment Invoice (DMAS-31) Rev 05/06 can also be ordered by contacting the DMAS forms order desk.

The CMS-1500 must be original forms when submitting for processing.

The CMS-1500 (12-90) or CMS-1500 (08/05) claim form will not be provided by DMAS.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835.

In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (800)-924-6741.

CLAIM INQUIRIES AND RECONSIDERATION

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800- 884-9730	Toll-free throughout the United States
1-804- 965-9732	Richmond and Surrounding Counties
1-804- 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

BILLING PROCEDURES

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27443
Richmond, Virginia 23261-7443

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will be ended for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will accepted.

Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted).

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated claims (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: http://virginia.fhsc.com.

CLAIMCHECK

Re-implementation of ClaimCheck editing software was done January 9, 2006 for all physician and laboratory services received on this date. ClaimCheck is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimCheck edits are based on the following global claim factors: sme recipient, same provider, same date of service or date of service is within established pre- or post-operative time frame. DMAS will recognize the following modifiers, when appropriately used as defined by the most recent Current Procedural Terminology (CPT), to determine the appropriate exclusion from the ClaimCheck process. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. The Division of Program Integrity will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

The modifiers that currently bypass the ClaimCheck edits are:

- Modifier 24 – Unrelated E & M service by the same physician during the post-operative period
- Modifier 25 – Significant, separately identifiable E & M service on the same day by the same physician on the same day of the procedure or other services.
- Modifier 57 – Decision for Surgery
- Modifier 59 – Distinct Procedural Service
- Modifiers U1-U9 – State-Specific Modifiers

Providers that disagree with the action taken by a ClaimCheck edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Department of Medical Assistance Services
Payment Processing Unit – ClaimCheck
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Reconsideration /Appeals

Requests for reconsideration of denied services, resulting from claimcheck should be sent with additional supporting documentation to:

Payment Processing Unit, Claim Check
Division of Program Operations

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-day time limit form the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

Provider Appeals

If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§9-6.14:1 through -6.14:25) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia et seq and § 32.1-325.1.

BILLING INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING PRIOR AUTHORIZATION

Please refer to the “Prior Authorization” section in appendix D of this manual.

UB-92 (CMS-1450) BILLING INSTRUCTIONS
(These instructions will be deleted after May 22, 2007 since the UB-92 is inactive as of May 23, 2007.)

Instructions for Completing the UB-92 (CMS-1450) Universal Claim Form

The UB-92 (CMS-1450) is a universally accepted claim form that is required when billing DMAS for covered services. This form is readily available from printers. The UB-92 (CMS-1450) **will not** be provided by DMAS. (See "Exhibits" at the end of this chapter for a sample of this form).

General Information:

The following information is applicable to Medicaid claims submitted by the provider on the UB-92 (CMS-1450):

- All dates used on the UB-92 (CMS-1450) must be two digits each for the day, the month, and the year (e.g., 010403) with the exception of Locator 14, Patient Birthdate, which requires four digits for year.

  NOTE: NO SLASHES, DASHES OR SPACES ARE ALLOWED.

- Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.

- Do not record cost reduction copayments on this form.

- When coding ICD-9-CM diagnostic and procedure codes, do not include the decimal point. The use of the decimal point may be misinterpreted in claims processing.

- To adjust a previously paid claim, complete the UB-92 (CMS-1450) to reflect the proper conditions, services, and charges. In addition, in Locator 4 (Type of Bill) enter code 817 for Hospice or 827 for Inpatient Hospice and, in locator 37, enter the nine to sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher. Enter the reason code and an explanation for the adjustment in Remarks, Locator 84.

- To void a previously paid claim, complete the following data elements on the UB-92 (CMS-1450):

  - Bill Type 818 for: Routine Home Care, Continuous Home Care, Inpatient Respite Care (if not provided in hospital setting), General Inpatient Care (if not provided in hospital setting), and Nursing Facility Resident

  - Bill Type 828 for: Inpatient Respite Care (in a hospital setting), and

General Inpatient Care (in a hospital setting)

- ICN/DCN (Locator 37) - Enter the nine to sixteen digit claim reference number of the paid claim to be voided. Enter the reason code and an explanation in Remarks, Locator 84.
- Payer Indicator (Locator 50) - Enter "Medicaid" here.
- Medicaid Provider Number (Locator 51) - Enter the Medicaid provider number.
- Recipient ID Number (Locator 60) - Enter the enrollee's Virginia Medicaid number.

UB-92 (CMS-1450) INVOICE INSTRUCTIONS

The following description outlines the process for completing the UB-92 CMS-1450. It includes Medicaid specific information and should be used to supplement the material included in the *State UB-92 Manual*.

Form Locator (FL)		Instructions
1	**Required**	Enter the provider's name, address, and telephone number.
2	Unlabeled Field	
3	**Required (if applicable)**	**PATIENT CONTROL NO. -** Enter the patient account number. These account numbers may be all numeric digits or a combination of alpha and numeric, but cannot exceed 17 alphanumeric characters.
4	**Required**	**Type of Bill** – Enter the code as appropriate. For billing on the UB-92, the only valid codes for Virginia Medicaid are: 811 Original Nursing Facility Hospice Invoice 817 Original Nursing Facility Hospice Invoice - Adjustment 818 Original Nursing Facility Hospice Invoice - Void **NOTE:** For the above bill types, the revenue code that is billed for Nursing Facility services which are provide by Hospice is 0658 – Nursing Facility Resident. 821 Original Inpatient Hospital Hospice Invoice 827 Original Inpatient Hospital Hospice Invoice - Adjustment 828 Original Inpatient Hospital Hospice Invoice – Void **NOTE:** For the above bill types, the revenue code that is billed for Inpatient Hospital Services which are provided by Hospice are 0653 – General Inpatient Care **OR** 0655 – Inpatient Respite Care. 831 Original Outpatient Hospice Services Invoice 837 Original Outpatient Hospice Services Invoice – Adjustment 838 Original Outpatient Hospice Services Invoice – Void

Form Locator (FL)		Instructions
		NOTE: For the above bill types, the revenue code that is billed for Outpatient Services which are provided by Hospice are 0651 – Routine Home Care **OR** 0652 – Continuous Home Care. <u>For Medicare Crossover Claims:</u> These are claims where Medicare is the primary payer and the Department of Medical Assistance Services (DMAS) is secondary. Medicare claims will automatically crossover to Medicaid for payment of co-insurance and deductible balances. DMAS will then adjudicate the claim and pay any remaining balance up to our allowable amount. For providers that have remaining nursing facility charges that are not covered by Medicare, these charges would be billed with bill type 811 and revenue code 0658 (include your usual and customary charges). In locator 39, providers will indicate the appropriate Coordination of Benefits (COB) code (see locator 39). The payment from Medicare plus the payment by Medicaid for the co-insurance and deductible balances would be shown with COB code = 83. DMAS will calculate our standard reimbursement minus the total payment amount, indicated in locator 39.
5	Not required	FED. TAX NO.
6	**Required**	**STATEMENT COVERS PERIOD** - Enter the inclusive days being reported on the invoice. The "through" entry must be the last day billed. The date of death or discharge, if applicable, must be indicated. The "Statement Covers Period" on the invoice must fall within one calendar month. When there is a claim for which the billing period overlaps calendar months, a separate invoice must be submitted for each calendar month. For example, an enrollee admitted to a nursing home on March 15 and discharged April 30. One invoice would be submitted for the period of March 15 through March 31, and one invoice would be submitted for the period of service in April.
7	**Required**	**COV D. (Covered Days)** - Enter the total number of Medicaid <u>covered</u> days as applicable. This must be the total number of covered accommodation revenue code units reported in Locator

Form Locator (FL)		Instructions
		46.
8	**Required (if applicable)**	**N-CD. (Non-Covered Days)** - Enter the days of care not covered. Non-covered days are not included in covered days and not claimable as Medicaid patient days on the cost report.
9	Not required	C-ID. (Coinsurance Days)
10	Not required	L-RD. (Lifetime Reserve Days)
11	Unlabeled Field	
12	**Required**	**PATIENT NAME** - Enter the patient's name - last, first, middle initial.
13	Not required	Patient Address - Enter the patient's address.
14	**Required**	**Birthdate -** Enter the month, date, and full year (MMDDYYYY).
15	**Required**	**Sex** - Enter the sex of the patient as recorded at the date of admission, outpatient service, or start of care.
16	**Optional**	**MS (Patient's Marital Status)** - Enter the marital status of the patient at the date of admission or the start of care. The codes are: S = Single M = Married X = Legally Separated D = Divorced W = Widowed U = Unknown
17	**Required**	**ADMISSION** - Enter the date of admission to the Nursing Facility for bill type 811 series and revenue code 0658. For all other bill types (821 series with revenue codes 0653 or 0655; OR 831 series with revenue codes 0651 or 0652) enter the start of care date for Hospice services.
18	Not required	HR (Admission Hour)
19	**Required (if applicable)**	**Type** (Type of Admission) - Enter the type of admission for any Inpatient Hospice Service for type 811 series and revenue code 0658; OR for bill type 821 series with revenue codes 0653 or

Form Locator (FL)		Instructions
		0655; enter the type of admission as Hospice services.
20	**Required**	**SRC (Source of Admission)** - Enter the proper code as follows:
		1 Physician Referral (used for both Inpatient and Outpatient referrals)
		2 Clinic referral (used for both Inpatient and Outpatient referrals)
		3 MCO referral (used for both Inpatient and Outpatient Referrals)
		4 Transfer from a hospital
		5 Transfer from a skilled nursing home
		6 Transfer from another health care facility
		7 Emergency room
		8 Court/law enforcement
		9 Information not available
		A Transfer from a critical access hospital
21	Not required	D HR (Discharge Hour)
22	**Required**	**STAT (Patient Status)** - Enter the status code as of the through date in Statement Covers Period (Locator 6). (If the patient was a one-day stay, enter code "30.")
		DMAS does not pay for a nursing home bed to be held while a patient is hospitalized.
		For a patient in the nursing home a whole month, the “from” date will be the first day of the month. The “through” date is the last day of the month (*e.g.*, from 03/01/03 through 03/31/03). The patient status code will be 30 (still a patient) which ensures payment for the last day.
		When a patient is admitted to a hospital or discharged (*e.g.*, on 04/14/03), bill for 04/01/03 to 04/14/03, using the appropriate codes 1-8 (discharge codes). The day of death or discharge is not a covered day, so the accommodation days will be 13. Locators 6 and 46 must be coordinated and in agreement.

Form Locator (FL) Instructions

When status codes 1-8 are used in Locator 22, the "through" date is not a paid accommodation day.

If the patient returns to the nursing home, a second bill will begin the date of the return to the home. If the patient returns on 04/25/03, the second bill for April will have "from" date of 04/25/03 "through" date of 04/30/03, patient status of 30.

DMAS does not pay for a nursing home bed to be held while a patient is hospitalized.

01 - Discharged to home or self care (routine discharge).

02 - Discharged/Transferred to another short term general hospital for inpatient care. The date the patient was transferred is the "through" date in locator 6. This day cannot be included in the accommodation charges in locator 46.

03 - Discharged/Transferred to skilled nursing facility (SNF). The day the patient was transferred is the "through" date in locator 6. This day cannot be included in the accommodation charges in locator 46.

05 - Discharged/Transferred to another type of institution for inpatient care or referred for outpatient services to another institution. The date the patient was discharged must be reported in locator 6 as the "through" date. This day cannot be included in the accommodation charges in locator 46.

06 - Discharged/Transferred to home under care of organized home health service organization. The date the patient was discharged must be reported in locator 6 as the "through" date. This day cannot be included in the accommodation charges in locator 46.

07 - Left against medical advice or discontinued care. The date the patient left must be reported in locator 6 as the "through" date. This date cannot be included in the accommodation charges in locator 46.

20 - Expired - The date of death must be reported in locator 6 as the "through" date. This date cannot be included in the

Form Locator (FL)		Instructions
		accommodation charges in locator 46.
23	**Optional**	**Medical Record No**. - Enter the number assigned to the patient's medical/health record by the provider for history audits. **NOTE**: This number should not be substituted for the Patient Control Number (Loc. 3) which is assigned by the provider to facilitate retrieval of the individual financial record.
24-30	Not required	Condition Codes
31	Unlabeled Field	
32-35	**a-b Required (if applicable)**	**OCCURRENCE CODES AND DATES** - Enter the code(s) in numerical sequence (starting with 01) and the associated date to define a significant event relating to this bill that may affect payer processing. **01 - Auto Accident** - Code indicating the date of an auto accident **02 - No Fault Insurance Involved-Including Auto Accident/Other -** Code indicating the date of an accident including auto or other where the state has applicable no fault liability laws (*i.e.*, legal basis for settlement without admission of proof of guilt) **03 - Accident/Tort Liability -** Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability **04 - Accident/Employment Related -** Code indicating the date of an accident allegedly relating to the patient's employment **05 - Other Accident -** Code indicating the date of an accident not described by the above codes **06 - Crime Victim -** Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties
36	Not required	Occurrence Span Codes and Dates

Form Locator (FL)		Instructions
37	**a-c Required (if applicable)**	**INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)** - Enter the nine- to sixteen digit claim reference number of the paid claim to be **adjusted** or **voided**. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). See the instructions for adjustments and voids for the specific reasons. **NOTE:** A = Primary Payer B = Secondary Payer C = Tertiary Payer Cross Reference to Payer Identification in Locator 50 A, B, C (Payer Identification).
38	**Optional**	**Responsible Party Name and Address**
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate code(s) to relate amounts or values to identified data elements necessary to process this claim. The Medical Assistance Program is always the payer of last resort when other health insurance coverage is available. Thus, all other insurance companies must be billed and payment received before billing the Medical Assistance Program. Other health insurance coverage will be provided at the time of verification of the enrollee's eligibility. This code consists of a three-digit numerical code denoting a possible carrier. Information for these carriers must be obtained by contacting the appropriate carrier. **Each** claim submitted **must** include the appropriate code in locator 39 to indicate the primary carrier billing status. One of the following codes **must** be used: **82 - No Other Coverage -** If the enrollee has no insurance coverage other than Medicaid. **83 - Billed and Paid -** The Medical Assistance Program must only be billed if the amount paid by the primary carrier is less than the charge for the covered services rendered. If the provider has received payment from the primary carrier(s) other than Medicare Part A, code 83 must be entered, all applicable charges must be entered, and the

Form Locator (FL) **Instructions**

amount covered by the primary carrier entered under the amount section of the locator.

85 - Billed and Not Paid - It is possible that the health insurance coverage of the primary carriers may exclude a particular type of service that is covered under the Medical Assistance Program, or, after billing the primary carrier, it may be determined that the enrollee's other coverage for certain benefits may be exhausted. In either case, Code 85 must be entered. The use of Code 85 must be accompanied by an attachment that contains the following information: the name of the insurance, the date of denial, and the reason for denial or non-coverage. This denial must be part of the patient's record and available for audit.

42 **Required** **REV. CD. (Revenue Codes) -** Enter the appropriate revenue code(s) which identify a specific accommodation, ancillary service, or billing calculation.

Code = 4 digits, right justified, use leading zeros

0651 Routine home care is in-home care that is not continuous (less than 8 hours per day). (one unit = 1 day)

0652 Continuous home care consists of in-home care that is predominantly nursing care and is provided as short–term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care. (one unit = 1 hour)

0653 General inpatient care may be provided in an approved freestanding hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one unit = 1 day)

0655 Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five consecutive days of respite care will be allowed (one unit = 1 day). Payment for the sixth day and any subsequent days of respite care is made at the routine home care rate (Z9430)

Form Locator (FL)		Instructions

0658 Nursing facility resident who has elected the hospice benefit (one unit = 1 day). Procedure code 0658 must be billed in conjunction with either procedure code 0651 (routine home care) or 0652 (continuous home care), which are billed as outpatient services with bill type 831 (see below). Hospice will be reimbursed 95% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care.

For the bill type 0811, 0817, and 0818 series, the revenue code that is billed for Nursing Facility services which are provide by Hospice is 0658 – Nursing Facility Resident.

For the bill type 0821, 0827, and 0828 series, the revenue code that is billed for Inpatient Hospital Services which are provide by Hospice are 0653 – General Inpatient Care **OR** 0655 – Inpatient Respite Care.

For the bill type 0831, 0837, and 0838 series, the revenue code that is billed for Outpatient Services which are provide by Hospice are 0651 – Routine Home Care **OR** 0652 – Continuous Home Care.

43	**Required**	**DESCRIPTION - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the *State UB-92 Manual*).**
44	**Required**	**CPCS/RATES -** Enter the accommodation rate.
45	Not required	SERV. DATE - Enter the date the service was provided.
46	**Required**	**SERV. UNITS -** Enter the total number of covered accommodation days or ancillary units of service where appropriate.
47	**Required**	**TOTAL CHARGES (by Revenue Codes)** - Enter the total charge(s) pertaining to the related revenue code for the current billing period - total charges must include only covered charges.

Instructions for "0001"

Use revenue code "0001" for TOTAL. THIS REVENUE CODE MUST BE THE LAST CODE ENTERED IN LOCATOR #42.

Form Locator (FL)		Instructions
48	**Required**	**NON-COVERED CHARGES** - Reflects non-covered charges for the primary payer pertaining to the related revenue code. **Note**: Use revenue code "0001" for TOTAL Non-Covered Charges. (Enter the total for both total charges and non-covered charges on the same line of revenue code "0001.")
49	Unlabeled Field	
50	**A-C Required**	**PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill. A = Enter the primary payer. B = Enter the secondary payer if applicable. C = Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C.
51	**A-C Required**	**PROVIDER NO.** - Enter the Provider I.D. NUMBER on the appropriate line corresponding with the payer name in locator 50. A = Primary B = Secondary C = Tertiary
52	A-C Not Required	REL INFO (Release Information) - Certification Indicator
53	A-C Not Required	ASG BEN (Assignment of Benefits) - Certification Indicator
54	**A, B, C, P Required (if applicable)**	**PRIOR PAYMENTS (Payers and Patients)** **Note:** A = Primary B = Secondary C = Tertiary P = Due from Patient **Enter the patient pay amount on "P" line as shown on the DMAS-122 form furnished by the Local Department of Social Services. (See "Exhibits" at the end of this chapter for a**

Form Locator (FL)		Instructions
		sample of this form.)
55	Not required A, B, C, P	Est. Amount Due
56	Unlabeled Field	
57	Unlabeled Field	
58	**A-C Required**	**INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the name when eligibility is confirmed. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. Enter the insured's name used by the primary payer identified on Line A, Locator 50. Enter the insured's name used by the secondary payer identified on Line B, Locator 50. Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**Required**	**(if P. REL applicable)**
60	**A-C Required**	**CERT.-SSN-HIC.-ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58. **NOTE:** The Medicaid Enrollee ID# is 12 digits.
61	Not Required	Group Name
62	Not Required	Insurance Group No.
63	Not Required	Treatment Authorization Codes
64	Not required	ESC (Employment Status Code)
65	Not required	Employer Name

Form Locator (FL)		Instructions
66	Not Required	Employer Location
67	**Required**	**PRIN. DIAG. CD.** - Enter the ICD-9-CM diagnosis code that describes the principal diagnosis. **DO NOT USE DECIMALS.**
68-75	**Required (if applicable)**	**Other Diagnosis Code(s)** - Enter the codes for diagnoses other than principal if any. **DO NOT USE DECIMALS.**
76	Not required	Adm. Diag. Cd. - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician.
77	Not Required	E-Code (External Cause of Injury Code)
78	Unlabeled Field	
79	**Required**	**P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 - HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if applicable)**	**Principal Procedure Code and Date** - Enter the ICD-9-CM procedure code for the principal procedure performed during the billing period.
81	**Required (if applicable)**	**Other Procedure Codes & Dates** - Enter the code(s) identifying all significant procedures other than the principal procedure (and the dates) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal. **DO NOT USE DECIMALS.**
82	**Required**	**ATTENDING PHYS. ID. NUMBER -** Enter the attending physician's seven to nine digit Medical Assistance Program identification number. If the physician does not participate in the Virginia Medical Assistance Program, use the following number

Form Locator (FL)		Instructions
		99-0002-1 (Practitioner, Non Participating).
83	**Required (if applicable)**	**OTHER PHYS. ID** - Instructions are the same as for the attending physician in locator 82 above. **If revenue code 0658 is billed, enter the nursing facility provider number in this block. The provider number is 9 digits.**
84	**Required (if applicable)**	**REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37). Also, if there is a delay in filing, indicate the reason for the delay here and include an attachment. Also, provide any other information necessary to adjudicate the claim.
85	**Required**	**PROVIDER REPRESENTATIVE** - Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. Required for paper claims only.
86	**Required**	**Date -** Enter the date on which the bill is submitted to Medicaid. Required for paper claims only.

Adjustment Invoice Instructions

The UB-92 (CMS-1450) is used as an adjustment invoice to change information on a paid claim. Only one line may be billed on an adjustment invoice. Follow the previous instructions for completion of the UB-92 (CMS-1450) except for the locators indicated below:

Form Locator (FL)		Instructions
4	**Required**	**Type of Bill - Enter the type of bill:** **817 Adjustment Nursing Facility Hospice** **827 Adjustment for Inpatient Hospital** **837 Adjustment for Outpatient Services**
37	**Required**	**Claim Reference Number** - Enter the nine to sixteen digit claim reference number of the paid claim. This number can be obtained from the remittance voucher and is required to identify the paid claim that is to be adjusted. **Note**: Only a paid claim may be adjusted. The former reference number must be located on the same line that Medicaid is shown in locator 50.
84	**Required**	**Remarks -** Enter a brief explanation of the reason for the adjustment.

Void UB-92 Invoice Instructions

The UB-92 (CMS-1450) is used as a void invoice when the full payment is to be returned to the Virginia Medical Assistance Program. Only one line may be billed on a void invoice. Follow the previous instructions for completion of the UB-92 (CMS-1450) except for the locators indicated below:

Form Locator (FL)		Instructions
4	**Required**	**Type of Bill - Enter the type of bill:** **818 Adjustment Nursing Facility Hospice** **828 Adjustment for Inpatient Hospital** **838 Adjustment for Outpatient Services**
37	**Required**	**Claim Reference Number** - Enter the nine to sixteen digit claim reference number of the paid claim. This number can be obtained from the remittance voucher and is required to identify the paid claim that is to be adjusted. **Note**: Only a paid claim may be adjusted. The former reference number must be located on the same line that Medicaid is shown in locator 50.
84	**Required**	**Remarks -** Enter a brief explanation of the reason for the void.

UB-04 (CMS-1450) BILLING INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING THE UB-04 CMS-1450 CLAIM FORM

DMAS will allow the use of this claim form beginning with claims received on or after April 1, 2007 but is mandatory for claims received on or after May 23, 2007.

Locator		Instructions
1	**Provider Name, Address, Telephone Required**	**Provider Name, Address, Telephone** - Enter the provider's name, complete mailing address and telephone number of the provider that is submitting the bill and which payment is to be sent. Line 1. Provider Name Line 2. Street Address Line 3. City. State, Line 4. Zip Code- **NOTE:** DMAS will need to have the 9 digit zip code on line four, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service. **Note**: DMAS **does not** require telephone/fax numbers.
2	**Pay to Name & Address Required if Applicable**	**Pay to Name & Address** - Enter the address of the provider where payment is to be sent, if different than Locator 1.
3a	**Patient Control Number Required**	**Patient Control Number** - Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.
3b	**Medical/Health Record Required**	**Medical/Health Record** - Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.
4	**Type of Bill Required**	**Type of Bill** - Enter the code as appropriate. Valid codes for Virginia Medicaid are: 0811 Original Inpatient Nursing Home Hospice Invoice 0812 Interim Inpatient Nursing Home Hospice Claim Form* 0813 Continuing Inpatient Nursing Home Hospice Claim Invoice* 0814 Last Inpatient Nursing Home Hospice Claim Invoice* 0817 Adjustment Inpatient Nursing Home Hospice Invoice 0818 Void Inpatient Nursing Home Hospice Invoice
	Note:	For the above bill types, the revenue code that is billed for Nursing Facility services which are provided by Hospice is 0658- Nursing

Locator		Instructions
		Facility Resident 0821 Original Inpatient Hospital Hospice Invoice 0827 Original Inpatient Hospital Hospice Invoice Adjustment 0828 Original Inpatient Hospital Hospice Invoice- Void
	Note:	For the above bill types, the revenue code that is billed for Inpatient Hospital Hospice Services which are provided by Hospice are 0653-General inpatient Care OR 0655 - Inpatient Respite Care. 0831 Original Outpatient Invoice 0837 Adjustment Outpatient Invoice 0838 Void Outpatient Invoice These below are for Medicare Crossover Claims Only
	Note:	For the above bill types, the revenue code that is billed for Nursing Home Outpatient Services which are provided by Hospice are 0651-Routine Home Care **OR** 0652 - Continuous Home Care.
5	Federal Tax Number Not Required	Federal Tax Number - The number assigned by the federal government for tax reporting purposes
7	Reserved for assignment by the NUBC	Reserved for assignment by the NUBC **NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.**
8	**Patient Name/Identifier Required**	**Patient Name/Identifier** - Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.
9	Patient Address	Patient Address - Enter the mailing address of the patient. a. Street address b. City c. State d. Zip Code (9 digits) e. Country Code if other than USA
10	**Patient Birthdate Required**	**Patient Birthdate -** Enter the date of birth of the patient. Note: The format for birthdate is MMDDYYYY. This is the only locator that the 4-digit year is to be used.

Locator		Instructions
11	**Patient Sex Required**	**Patient Sex -** Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U = unknown
12	**Admission/Start of Care Required**	**Admission/Start of Care -** The start date for this episode of care. For general Hospice this date is the date hospice began. For patients already in a nursing home facility, but elect hospice services the date hospice care began is to be entered. NOT the admission date to the nursing home.
13	**Admission Hour Required**	**Admission Hour -** Enter the hour during which the patient was admitted for inpatient or outpatient care. **Note**: Military time is used as defined by NUBC.
14	**Priority (Type) of Visit Required**	**Priority (Type) of Visit -** Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS for hospice are:

Code	Description
3	Elective - patient's condition permits adequate time to schedule the services
9	Information not available

15	**Source of Referral for Admission or Visit Required**	**Source of Referral for Admission or Visit -** Enter the code indicating the source of the referral for this admission or visit. **Note:** Appropriate codes accepted by DMAS are:

Code:	Description
1	Physician Referral
2	Clinic Referral
4	Transfer from Another Acute Care Facility
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility
9	Information not available

16	**Discharge Hour Required**	**Discharge Hour -** Enter the code indicating the discharge hour of the patient from inpatient care. **Note:** Military time is used as defined by NUBC

Locator		Instructions
17	**Patient Discharge Status Required**	**Patient Discharge Status -** Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are:

Code	Description
01	Discharged to Home
02	Discharged/transferred to Short term General Hospital for Inpatient Care
03	Discharged/transferred to Skilled Nursing Facility
04	Discharged/transferred to Intermediate Care Facility
05	Discharged/transferred to Another Facility not Defined Elsewhere
07	Left Against Medical Advice or Discontinued Care
20	Expired
30	Still a Patient
50	Hospice – Home
51	Hospice – Medical Care Facility
61	Discharged/transferred to Hospital Based Medicare Approved Swing Bed

18 thru 28	**Condition Codes Required if applicable**	**Condition Codes** – Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication. **Note**: DMAS limits the number of condition codes to maximum of 8 on one claim. These codes are used by DMAS in the adjudication of claims:

Code	Description
39	Private Room Medically Necessary
40	Same Day Transfer
A1	EPSDT
A4	Family Planning

29	**Accident State**	**Accident State** – Enter if known the state (two digit state abbreviation) where the accident occurred.

Locator		Instructions
30	**Crossover Part A Indicator**	**Note:** DMAS is requiring for Medicare Part A crossover claims that the word **"CROSSOVER"** be in this locator
31 thru 34	**Occurrence Code and Dates Required if applicable**	**Occurrence Code and Dates –** Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence. . An example of how providers should identify Medicare coverage exhausted on a Medicaid claim is A3= MDCR Exhaust
35 thru 36	**Occurrence Span Code and Dates Required if applicable**	**Occurrence Span Code and Dates –** Enter the code and related dates that identify an event relating to the payment of the claim. Enter codes in alphanumeric sequence.
37	Reserved	Reserved For NUBC Assignment
38	Responsible Party Name and Address	Responsible Party Name and Address – Enter the name and address of the party responsible for the bill.
39 thru 41	**Value codes and Amount Required**	**Value Codes and Amount -** Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim. **Note:** DMAS will be capturing the number of covered or non-covered day(s) or units for inpatient and outpatient service(s) with these required value codes: 80 Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. 81 Enter the number of non-covered days for inpatient hospitalization **AND** One of the following codes **must** be used to indicate the coordination of third party insurance carrier benefits: 82 No Other Coverage 83 Billed and Paid (enter amount paid by primary carrier) 85 Billed Not Covered/No Payment For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above: A1 Deductible from Part A A2 Coinsurance from Part A Other codes may also be used if applicable. The a, b, or c line containing this above information should Cross

Locator	Instructions
	Reference to Payer Name (Medicaid) in Locator 50 A, B, C.

42 Revenue Code Required

Revenue Codes - Enter the appropriate revenue code(s) for the service provided. Note:

- Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order,
- Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services,
- DMAS has a limit of five pages for one claim,
- The Total Charge revenue code (0001) should be the last line of the last page of the claim

0651 Routine home care is in-home care that is not continuous (less than 8 hours per day). (one unit = 1 day)

0652 Continuous home care consists of in-home care that is predominantly nursing care and is provided as short-term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care. (one unit = 1 hour)

0653 General inpatient care may be provided in an approved freestanding hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one unit = 1 day)

0655 Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five consecutive days of respite care will be allowed (one unit = 1 day). Payment for the sixth day and any subsequent days of respite care is made at the routine home care rate (Z9430).

Locator		Instructions
		0658 Nursing facility resident who elected the hospice benefit (one unit = 1 day). Procedure code 0658 must be billed in conjunction with either procedure code 0651 (routine home care) or 0652 (continuous home care), which are billed as outpatient services with bill type 0831. Hospice will be reimbursed 95% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care.
43	**Revenue Description Required**	**Revenue Description -** Enter the standard abbreviated description of the related revenue code categories included on this bill.
44	**HCPCS/Rates/ HIPPS Rate Codes Required (if applicable)**	**HCPCS/Rates/HIPPS Rate Codes -** Inpatient: Enter the accommodation rate.
45	**Service Date Required if applicable**	**Service Date -** Enter the date the outpatient service was provided.
46	**Service Units Required**	**Service Units -** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit).
47	**Total Charges Required**	**Total Charges -** Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non covered charges. **Note:** Use code "0001" for TOTAL.
48	**Non-Covered Charges Required if applicable**	**Non-Covered Charges -** To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.
49	Reserved	Reserved for Assignment by the NUBC.
50	**Payer Name A-C. Required**	**Payer Name -** Enter the payer from which the provider may expect some payment for the bill.

Locator		Instructions
		A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. This also applies to the Temporary Detention and Emergency Custody Order claims.
51	Health Plan Identification Number A-C	Health Plan Identification Number - The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill. **NOTE:** DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57
52	Release of Information Certification Indicator A-C	Release of Information Certification Indicator - Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.
53	Assignment of Benefits Certification Indicator A-C	Assignment of Benefits Certification Indicator - Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.
54	**Prior Payments – Payer A,B,C Required (if applicable)**	**Prior Payments Payer** – Enter the amount the provider has received (to date) by the health plan toward payment of this bill. **NOTE:** Long-Term Hospitals, and Hospice Nursing Facilities: Enter the patient pay amount on the appropriate line (a-c) that is showing Medicaid as the payer in locator 50. The amount of the patient pay is shown on the DMAS-122 Form furnished by the Local Department of Social Services Office or the Nursing Home. Note: A=Primary B=Secondary C=Tertiary **DO NOT ENTER THE MEDICAID COPAY AMOUNT**
55	Estimated Amount Due A,B,C,	Estimated Amount Due – Payer – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).

Locator		Instructions
56	**NPI Required**	**National Provider Identification** – Enter your NPI. Once DMAS is in the dual use period (March 26, 2007), providers will submit their NPI in this locator on the UB 04. Until March 26, 2007, providers should enter their legacy Medicaid number in locator 57.
57A thru C	**Other Provider Identifier Required (if applicable)**	**Other Provider Identifier** – Enter your legacy Medicaid provider number in this locator until DMAS is accepting NPI for claims processing which are claims submitted prior to March 26, 2007. Effective May 23, 2007, DMAS will not accept claims received with the legacy Medicaid number in this locator. For providers who are given an Atypical Provider Number (API), this is the locator that will be used. Enter the provider number on the appropriate line that corresponds to the recipient name in locator 50.
58	**Insured's Name A-C Required**	**INSURED'S NAME** – Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. • Enter the insured's name used by the primary payer identified on Line A, Locator 50. • Enter the insured's name used by the secondary payer identified on Line B, Locator 50. • Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**Patient's Relationship to Insured A-C Required**	**Patient's Relationship to Insured** - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are:

Code:	**Description:**
01	Spouse
18	Self
19	Child
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

Locator		Instructions
60	**Insured's Unique Identification A-C Required**	**Insured's Unique Identification** - For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. **NOTE:** The Medicaid recipient identification number is 12 numeric digits.
61	(Insured) Group Name A-C	(Insured) Group Name - Enter the name of the group or plan through which the insurance is provided.
62	Insurance Group Number A-C	Insurance Group Number - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.
63	**Treatment Authorization Code Required (if applicable)**	**Treatment Authorization Code** - Enter the 11 digits preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid.
64	**Document Control Number** (DCN) **Required for adjustment and void claims**	**Document Control Number** - The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. **Note:** This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.
65	Employer Name (of the Insured) A-C	Employer Name (of the Insured) - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**Diagnosis and Procedure Code Qualifier Required**	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator) –** The qualifier that denotes the version of the International Classification of Diseases. Qualifier = 9 for Ninth Revision. **Note:** DMAS will only accept a 9 in this locator.
67	**Principal Diagnosis Code Required**	**Principal Diagnosis Code** – Enter the ICD-9-CM diagnosis code that describes the principal diagnosis (i.e., the condition established after study to chiefly responsible for occasioning the admission of the patient for care).
67 & 67A-Q	Present on Admission (POA) Indicator Required	Present on Admission (POA) Indicator – The eighth digit of the Principal, Other Diagnosis and External Cause of Injury Codes are to be indicated if: • the diagnosis was known at the time of admission, or • the diagnosis was clearly present, but not diagnosed, until after admission took place or • was a condition that developed during an outpatient

Locator		Instructions
		encounter. **Note:** Not Required for Hospice Services
67 A thru Q	**Other Diagnosis Codes Required if applicable**	**Other Diagnosis Codes** Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. **DO NOT USE DECIMALS.**
68	**Special Note**	**Note:** Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 – miscellaneous void or 1053 – miscellaneous adjustment.
69	**Admitting Diagnosis Required**	**Admitting Diagnosis –** Enter the diagnosis code describing the patient's diagnosis at the time of admission. **DO NOT USE DECIMALS.**
70 a-c	Patient's Reason for Visit	Patient's Reason for Visit **–** Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration.
71	Prospective Payment System (PPS) Code	Prospective Payment System **–** Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72	**External Cause of Injury Required if applicable**	**External Cause of Injury** – Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. **DO NOT USE DECIMALS.**
73	Reserved	Reserved for Assignment by the NUBC
74	**Principal Procedure Code and Date Required if applicable**	**Principal Procedure Code and Date –** Enter the ICD-9-CM procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date. **Note:** For outpatient claims, a procedure code must appear in this locator when revenue codes 0360-0369, 0420-0429, 0430-0439, and 0440-0449 (if covered by Medicaid) are used in Locator 42 or the claim will be rejected.
74a-e	**Other Procedure Codes and Date**	**Other Procedure Codes and Date –** Enter the ICD-9-CM procedure codes identifying all significant procedures other than the

Locator		Instructions
	Required if applicable	principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. **DO NOT USE DECIMALS.**
75	Reserved	Reserved for assignment by the NUBC
76	**Attending Provider Name and Identifiers Required**	**Attending Provider Name and Identifiers** – Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Inpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will not be accepted until April 1, 2007, and then the NPI may be entered in the "NPI" space. After May 22, 2007, only the attending physicians' NPI will be accepted in the "NPI" space. Outpatient: Enter the 9-digit number assigned by Medicaid for the physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will not be accepted until April 1, 2007, and then the NPI may be entered in the "NPI" space. After May 22, 2007, only the physicians' NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is '82' (Rendering Provider) whenever the legacy Medicaid number is entered. **Note:** If the NPI is in locator 56, then this locator must also have the attending providers NPI.
77	**Operating Physician Name and Identifiers Required if applicable**	**Operating Physician Name and Identifiers** – Enter the name and the 9-digit number assigned by Medicaid of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim. Inpatient: Enter the 9-digit number assigned by Medicaid for the operating physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will not be accepted until April 1, 2007, and then the NPI may be entered in the "NPI" space. After May 22, 2007, only the operating physicians' NPI will be accepted in the "NPI" space. Outpatient: Enter the 9-digit number assigned by Medicaid for the operating physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use

Locator		Instructions
		period. The UB-04 form will not be accepted until April 1, 2007, and then the NPI may be entered in the "NPI" space. After May 22, 2007, only the physicians' NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is either '82' (Rendering Provider), 'DN' (Referring Provider) or 'ZZ' (Other Operating Physician) whenever the legacy Medicaid number is entered.
78 - 79	**Other Provider Name and Identifiers Required if applicable**	**Other Physician ID.** – Enter the 9 digit provider number assigned by Medicaid. For Hospice Providers: If revenue code 0658 is billed, then enter the nursing facility provider number in this locator. Please refer below to the time frame for entrance of either the legacy Medicaid provider number or the NPI. **Note:** Until DMAS has implemented the dual use period on March 26, 2007 the legacy Medicaid number or the providers NPI can be entered. The UB-04 form will not be accepted until April 1, 2007, and then the NPI may be entered in the "NPI" space. After May 22, 2007, only the physician's NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is 'DN' (Referring Provider) whenever the legacy Medicaid number is entered.
80	**Remarks Field**	**Remarks Field** – Enter additional information necessary to adjudicate the claim. Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Provide other information necessary to adjudicate the claim.
81	**Code-Code Field Required if applicable**	**Code-Code Field** – Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS will be using this field to capture taxonomy for claims that are submitted with one NPI for multiple business types or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations). **Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.**

Note: Hospice providers with **one** NPI must use a taxonomy code when submitting claims for different business types. (one NPI for 2 or more Medicaid PIN)

Service Type Description	Taxonomy Code(s)
Community Based Hospice	251G00000X
Inpatient Hospice	351D00000X

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7443

Maintain the Institution copy in the provider files for future reference.

UB-04 (CMS-1450) ADJUSTMENT IVOICE AND VOID INVOICE INSTRUCTIONS

- To **adjust** a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.

  - Type of Bill (Locator 4) **–** Enter code 0817, 0827 for inpatient Nursing Home Hospice Services or enter code 0837 for outpatient Hospice services.

  - Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.

  - Locator 68 – Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.

  - Remarks (Locator 80) **–** Enter an explanation for the adjustment.

  NOTE: Inpatient Hospice claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

    - Admission Date
    - From or Through Date
    - Discharge Status
    - Diagnosis Code(s)
    - Procedure Code(s)

Acceptable Adjustment Codes:

Code	Description
1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/ service code
1029	Correcting diagnosis code
1030	Correcting charge
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

- To **VOID** a previously paid claim, complete the following data elements on the UB-04 CMS-1450:

- Type of Bill (Locator 4) **–** Enter code 0818, 0828 for inpatient Hospice services or enter code 0838 for outpatient Hospice services.

- Locator 64 – Document Control Number **–** Enter the sixteen digit claim reference number of the paid claim to be voided. The claim reference number appears on the remittance voucher.

- Locator 68 – Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS.

- Remarks (Locator 80) **–** Enter an explanation for the void.

Acceptable Void Codes:

Code	**Description**
1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, "less the negative balance" and it may also show "the negative balance to be carried forward".

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

EDI BILLING (ELECTRONIC CLAIMS)

Please refer to X-12 Standard Transactions & our Comparison Guides that are listed in the chapter.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
    - **Approved** – Payment is approved or Pended. Pended claims are placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** – Payment cannot be approved because of the reason stated on the remittance voucher.
    - **Pend** – Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

EXHIBITS

	Page
UB-92 (CMS-1450) Form	1
UB-04 (CMS-1450) Form	2

NOTE: **DMAS has removed the previous rate tables from the exhibit section in this manual. Hospice rates can be found on our website: www.dmas.virginia.gov. Click on Provider Services and then click on Hospice Rates.**

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7 COV. D. / 8 N-C. D. / 9 C-I. D. / 10 L-R. D. / 11
12 PATIENT NAME	13 PATIENT ADDRESS		
14 BIRTHDATE / 15 SEX / 16 M-S	ADMISSION: 17 DATE / 18 HR / 19 TYPE / 20 SRC	21 D HR / 22 STAT / 23 MEDICAL RECORD NO.	CONDITION CODES: 24 / 25 / 26 / 27 / 28 / 29 / 30 / 31

	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE CODE / DATE	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a						A
b						B
						C

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a -	-	-
	b -	-	-
	c -	-	-
	d -	-	-

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1						-	-	
2						-	-	
3						-	-	
4						-	-	
5						-	-	
6						-	-	
7						-	-	
8						-	-	
9						-	-	
10						-	-	
11						-	-	
12						-	-	
13						-	-	
14						-	-	
15						-	-	
16						-	-	
17						-	-	
18						-	-	
19						-	-	
20						-	-	
21						-	-	
22						-	-	
23						-	-	

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR P. AYMENTS	55 EST. AMOUNT DUE	56
A					-	-	
B					-	-	
C					-	-	
57		DUE FROM PATIENT ▶			-	-	

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GR. OUP NAME	62 INSURANCE GR.OUP NO.
A					
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLO. YER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	82 ATTENDING PHYS. ID
		A	B	
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	83 OTHER PHYS. ID
	C	D	E	A
a	84 REMARKS			OTHER PHYS. ID
b				B
c				85 PROVIDER REPRESENTATIVE / 86 DATE
d				X

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28	29 ACDT STATE	30

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a						a
b						b

38	39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a		
	b		
	c		
	d		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
							1
							2
							3
							4
							5
							6
							7
							8
							9
							10
							11
							12
							13
							14
							15
							16
							17
							18
							19
							20
							21
							22
	PAGE ___ OF ___	CREATION DATE		TOTALS			23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
						57 OTHER PRV ID	A B C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
					A B C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
			A B C

66 DX										68

69 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		